South Carolina Department of Health and Human Services
MIAP ADDENDUM TO MEDICAID APPLICATION

THIS IS NOT A VALID MIAP APPLICATION UNLESS IT IS ATTACHED TO A MEDICAID APPLICATION.

I. APPLICANT – IDENTIFYING INFORMATION

☐ Emergency ☐ Non-Emergency Admission Date: _____ Hospital: _____
Applicant Name: _____ Social Security Number: _____
How long at current address? _____If less than 6 months, give previous address, including county:
_____
Is applicant a minor who does not live in the home of his parent(s)? ☐ Yes ☐ No If yes, give parent(s) name, address, and county of residence: _____

II. THIRD PARTY INFORMATION ON APPLICANT

1. Is illness due to an accident? ☐ Yes ☐ No If yes, what type? _____
   Date of accident: _____ Is claim pending? ☐ Yes ☐ No If work-related, give name and address of employer at time of accident: _____

2. Are you covered by Medicare? ☐ Yes ☐ No If yes, give Medicare claim number: _____

3. Have you applied for hospital services through another governmental program? ☐ Yes ☐ No
   If yes, check (✓) all blocks that apply: ☐ Veterans Administration ☐ Commission for the Blind ☐ DHEC
   ☐ Other (specify): _____ Date Applied: _____

III. INCOME

PROOF OF ALL INCOME RECEIVED FOR A 4-WEEK PERIOD WILL BE REQUIRED. THE ELIGIBILITY WORKER WILL DETERMINE WHICH 4 WEEKS, DEPENDING ON WHETHER THE ADMISSION WAS AN EMERGENCY OR A NON-EMERGENCY.

1. If not working now, when was your last day of employment? _____
   Employer Name and Address: _____

2. Have you or anyone in your family received a lump sum payment in the past 4 weeks (income tax refund, insurance settlement, etc.)? ☐ Yes ☐ No If, yes, amount: $ _____ From whom? _____

IV. RESOURCES

1. Where are your assets located, and how much do you owe on them?

Asset	Owner(s) (If jointly owned, list all owners)	Location	Amount Owed, if any

2. What is the year, make, and model of your motor vehicles, and how much do you owe on them?

Year, Make, and Model	Amount Owed

If your attached Medicaid application is for someone who is age 65 or older or disabled, you already answered #3 below, so you can skip it and go to section V. If your Medicaid application is for someone who is not age 65 or older or disabled, answer #3 below.

3. Do you or other family members own liquid assets (cash on hand, checking accounts, savings accounts, U. S. Savings Bonds, stocks, trust funds, certificates of deposit, face value of life insurance, individual retirement accounts, etc.)? ☐ Yes ☐ No If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

V. TRANSFER OF RESOURCES

Have you or other family members sold or given as a gift any resources in the past three (3) months? ☐ Yes ☐ No
If yes, give the following information:

Type	Owner(s) (If jointly owned, list all owners.)	Location	Account Number	Amount/Value

VI. STATEMENT OF UNDERSTANDING

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under the Medically Indigent Assistance Act.

I understand that if I believe an error has been made by the MIAP county designee in processing my MIAP application, I may request a reconsideration. This request must be made in writing, within 30 days from the date of the decision notice, to the person designated by the county's chief administrative officer to make reconsideration decisions. I understand that if I believe an error has been made in the reconsideration decision, I have the right to appeal this decision at a hearing with SCDHHS, the agency that administers Medicaid in South Carolina. I may represent myself at the hearing, hire an attorney to help me or have someone speak on my behalf. I must submit a written request for a hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- Online at www.scdhhs.gov/appeals • Faxed to: 888-835-2086 • Emailed to: eligappeals@scdhhs.gov.
- Mailed to: SCDHHS – Central Mail, PO Box 100101, Columbia, SC 29202-3101, Attn:Eligibility Appeals

In the appeal request, I should specifically state which issue(s) I wish to appeal and attach a copy of the notification regarding the specific matter on appeal.

(For more information about the appeal process or what to include in your appeal request, go to www.scdhhs.gov/appeals, call 888-835-2039 or send an email to eligappeals@scdhhs.gov.)

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am liable for prosecution for fraud. By my signature, I authorize the release of any information needed to determine my eligibility for the Medically Indigent Assistance Program.

Signature of Applicant or Authorized Representative:	Date:
Title/Relationship of Authorized Representative, if applicable:	
Signature of Witness (if applicant signed with an "X")	Date:
Signature of Witness (if applicant signed with an "X")	Date:
Signaure of County Designee:	Date:

VII. CASE NOTES

WORKSHEET

The eligibility factors identified below must be met before an applicant can be certified for assistance through the MIAP. Please indicate if each factor is met and how it was verified.

1. Is applicant a state resident? ☐ Not Questionable ☐ Questionable
   If questionable, how verified? _____
2. Is applicant a citizen or a permanent resident alien? ☐ Not Questionable ☐ Questionable
   If questionable, how verified? _____
3. Number of family members

   Explain who was included/excluded in the family composition and why.

   Family Income – Whose income was included in the calculation?

   How was it verified and calculated?

TOTAL GROSS ANNUAL INCOME

4. Family Resources
   A. Home Property (Identify the asset, to whom it belongs and the equity value.)

   Method and Date of Verification

   MIAP Limit $35,000.00

TOTAL VALUE OF HOME PROPERTY

   B. Non-home real property and taxable personal property (Identify the asset, to whom it belongs, and the equity value.)

   Method and Date of Verification

   MIAP Limit $6,000.00

TOTAL VALUE OF NON-HOME REAL AND TAXABLE PERSONAL PROPERTY

   C. Liquid Assets (Identify the asset, to whom it belongs, and the value.)

   Method and Date of Verification

   MIAP Limit $500.00

TOTAL VALUE OF LIQUID ASSETS

   Does the applicant's liquid assets (4C) exceed the MIAP limit? ☐ Yes ☐ No
   If yes, by how much? $ _____

   Did the applicant spend the excess on valid debts of the family which were incurred within thirty (30) days of hospitalization? ☐ Yes ☐ No If yes, how verified?

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။